(HH) Nursing Facility (NF). Effective October 1, 1990, Skilled Nursing Facilities, Skilled Nursing Facilities/Intermediate Care Facilities and Intermediate Care Facilities as defined in Chapter 198 RSMo participating in the Medicaid Program will all be subject to the minimum Federal requirements found in section 1919 of the Social Security Act.

(II) Occupancy Rate. A facility's total actual patient days divided by the total bed days for the same period as determined from the desk audited and/or field audited cost report. For a distinct part facility that completes a worksheet one (1) of cost report, version MSIR (7-93), determine the occupancy rate from the total actual patient days from the certified portion of the facility divided by the total bed days from the certified portion for the same period, as determined from the desk audited and/or field audited cost report.

(JJ) Patient Care. This cost component includes the following lines from the cost report version MSIR-1 (7-93): lines 45-60,77-85.

(KK) Patient Day. The period of service rendered to a patient between the census-taking hour on two (2) consecutive days. Census shall be taken in all facilities at midnight each day and a census log maintained in each facility for documentation purposes. "Patient day" includes the allowable temporary leave-of-absence days per subsection (5)(D) and hospital leave days per subsection (5)(M). The day of discharge is not a patient day for reimbursement unless it is also the day of admission.

(LL) Per Diem. The daily rate calculated using this plan's cost components and used in the determination of a facility's prospective and/or interim rate.

(MM) Provider or Facility. A nursing facility with a valid Medicaid participation agreement with the Department of Social Services for the purpose of providing nursing facility services to Title XIX eligible recipients.

(NN) Prospective Rate. The rate determined from the rate setting cost report.

(OO) Rate Setting Period. The full twelve (12) month period in which a facility's prospective rate is determined. The rate setting period for a facility is determined from applicable plans on or after July 1, 1990.

(PP) Reimbursement Rate. A prospective or interim rate.

(QQ) Related Parties. Parties are related when any one (1) of the following circumstances apply:

1. An entity where, through its activities, one (1) entity's transactions are for the benefit of the other and such benefits exceed those which are usual and customary in such dealings.

2. An entity has an ownership or controlling interest in another entity; and the entity, or one (1) or more relatives of the entity, has an ownership or controlling interest in the other entity. For the purposes of this paragraph, ownership or controlling interest does not include a bank, savings bank, trust company, building and loan association, savings and loan association, credit union, industrial loan and thrift company, investment banking firm or insurance company unless the entity directly, or through a subsidiary, operates a facility.

3. As used in this plan, the following terms mean:

A. Indirect ownership/interest means an ownership interest in an entity that has an ownership interest in another entity. This term includes an ownership interest in any entity that has an indirect ownership interest in an entity;

*Substitute per letter dated 10/27/95 *

B. Ownership interest means the possession of equity in the capital, in the stock, or in the profits of an entity. Ownership or controlling interest is when an entity:

(I) Has an ownership interest totalling five percent (5%) or more in an entity;

(II) Has an indirect ownership interest equal to five percent (5%) or more in an entity. The amount of indirect ownership interest is determined by multiplying the percentages of ownership in each entity;

(III) Has a combination of direct and indirect ownership interest equal to five percent (5%) or more in an entity;

(IV) Owns an interest of five percent (5%) or more in any mortgage, deed of trust, note, or other obligation secured by an entity if that interest equals at least five percent (5%) of the value of the property or assets of the entity. The percentage of ownership resulting from these obligations is deter-mined by multiplying the percentage of interest owned in the obligation by the percentage of the entity's assets used to secure the obligation;

(V) Is an officer or director of an entity; or

(VI) Is a partner in an entity that is organized as a partnership.

C. Relative means person related by blood, adoption or marriage to the fourth degree of consanguinity.

(RR) Replacement Beds. Newly constructed beds never certified for Medicaid or previously licensed by the Division of Aging or the Department of Health and put in service in place of existing Medicaid beds. The number of replacement beds being certified for Medicaid shall not exceed the number of beds being replaced.

(SS) Renovations/Major Improvements. Capital cost incurred for improving a facility excluding replacement beds and additional beds.

(TT) Restricted Funds. Funds, cash, cash equivalents or marketable securities, including grants, gifts, taxes and income from endowments which must only be used for a specific purpose designated by the donor.

(UU) Total Facility Size. Facility size plus increases minus decreases of licensed nursing facility beds plus calculated bed equivalents for renovations/major improvements.

(VV) Unrestricted Funds. Funds, cash, cash equivalents or marketable securities, including grants, gifts, taxes and income from endowments, that are given to a provider without restriction by the donor as to their use.

(5) Covered Supplies, Items and Services. All supplies, items and services covered in the reimbursement rate must be provided to the resident as necessary. Supplies and services which would otherwise be covered in a reimbursement rate but which are also billable to the Title XVIII Medicare Program must be billed to that program for facilities participating in the Title XVIII Medicare Program. Covered supplies, items and services include, but are not limited to, the following:

(A) Services, items and covered supplies required by federal or state law or plan which must be provided by nursing facilities participating in the Title XIX Program;

(B) Semi-private room and board;

(C) Private room and board when it is necessary to isolate a recipient due to a medical or social condition examples of which may be contagious infection, loud irrational speech, etc.;

(D) Temporary leave of absence days for Medicaid recipients, not to exceed twelve (12) days for the first six (6) calendar months and not to exceed twelve (12) days for the second six (6) calendar months. Temporary leave of absence days must be specifically provided for in the recipient's plan of care and prescribed by a physician. Periods of time during which a recipient is away from the facility visiting a friend or relative are considered temporary leaves of absence;

(E) Provision of personal hygiene and routine care services furnished routinely and uniformly to all residents;

(F) All laundry services, including personal laundry;

(G) All dietary services, including special dietary supplements used for tube feeding or oral feeding. Dietary supplements prescribed by a physician are also covered items;

(H) All consultative services required by federal or state law or plans;

(I) All therapy services required by federal or state law or plans;

(J) All routine care items including, but not limited to, those items specified in Appendix A to this plan;

(K) All nursing services and supplies including, but not limited to, those items specified in Appendix A to this plan;

(L) All non-legend antacids, non-legend laxatives, non-legend stool softeners and non-legend vitamins. Providers may not elect which non-legend drugs in any of the four (4) categories to supply; any and all must be provided to residents as needed and are included in a facility's reimbursement rate; and

(M) Hospital leave days as defined in 13 CSR 70-10.070.

(6) Non-Covered Supplies, Items and Services. All supplies, items and services which are either not covered in a facility's reimbursement rate or are billable to another program in Medicaid, Medicare or other third party payor. Non-covered supplies, items and services include, but are not limited to, the following:

(A) Private room and board unless it is necessary to isolate a recipient due to a medical or social condition, examples of which may be contagious infection, loud irrational speech, etc. Unless a private room is necessary due to such a medical or social condition, a private room is a non-covered service and a Medicaid recipient or responsible party may therefore pay the difference between a facility's semi-private charge and its charge for a private room. Medicaid recipients may not be placed in private rooms and charged any additional amount above the facility's Medicaid reimbursement rate unless the recipient or responsible party specifically requests in writing a private room prior to placement in a private room and acknowledges that an additional amount not payable by Medicaid will be charged for a private room;

(B) Supplies, items and services for which payment is made under other Medicaid Programs directly to a provider or providers other than providers of the nursing facility services; and

(C) Supplies, items and services provided non-routinely to residents for personal comfort or convenience.

(7) Allowable Cost Areas.

(A) Compensation of Owners.

1. Compensation of services of owners shall be an allowable cost area. Reasonableness of compensation shall be limited as prescribed in subsection (8)(Q).

2. Compensation shall mean the total benefit, within the limitations set forth in this plan and consistent with and as defined by the Medicare Provider Reimbursement Manual, Part 1, Chapter 9, received by the owner for the services rendered to the facility. This includes direct payments for managerial, administrative, professional and other services, amounts paid for the personal benefit of the owner, the cost of assets and services which the owner receives from the provider, and additional amounts determined to be the reasonable value of the services rendered by sole proprietors or partners and not paid by any method previously described in this plan. Compensation must be paid (whether in cash, negotiable instrument, or in kind) within seventy-five (75) days after the close of the period in accordance with the guidelines published in the Medicare Provider Reimbursement Manual, Part 1, Section 906.4.

(B) Covered services and supplies as defined in section (5) of this plan.

(C) Capital Assets

1. Capital Assets shall include historical costs that would be capitalized under GAAP. For example, historical costs would include but not limited to, architectural fees, related legal fees, interest and taxes during construction.

2. For purposes of this plan, any asset or improvement costing greater than one thousand dollars ($1,000) and having a useful life greater than one (1) year in accordance with American Hospital Association depreciable guidelines, shall be capitalized.

3. In addition to the American Hospital Association depreciable guidelines, mattresses shall be considered a capitalized asset and shall have a three (3) year useful life.

(D) Depreciation - Vehicle.

1. An appropriate allowance for depreciation on vehicles which are a necessary part of the operation of a nursing facility is an allowable cost. One vehicle per 60 licensed beds is allowable. For example, one vehicle is allowed for a facility with 0-60 licensed beds, two vehicles are allowed for a facility with 61-120 licensed beds, etc. Depreciation is treated as an administration cost and is reported on line 139 of the cost report, version MSIR-1 (7-93).

2. The depreciation must be identifiable and recorded in the provider's accounting records, based on the basis of the vehicle and prorated over the estimated useful life of the vehicle in accordance with American Hospital Association depreciable guidelines using the straight line method of depreciation from the date initially put into service.

3. The basis of vehicle cost at the time placed in service shall be the lower of:

A. the book value of the provider;

B. fair market value at the time of acquisition; or

C. the recognized IRS tax basis.

4. The basis of a donated vehicle will be allowed to the extent of recognition of income resulting from the donation of the vehicle. Should a dispute arise between a provider and the Division as to the fair market value at the time of acquisition of a depreciable vehicle, an appraisal by a third party is required. The appraisal cost will be the sole responsibility of the nursing facility.

5. Historical cost will include the cost incurred to prepare the vehicle for use by the nursing facility.

6. When a vehicle is acquired by trading in an existing vehicle, the cost basis of the new vehicle shall be the sum of undepreciated cost basis of the traded vehicle plus the cash paid.

(E) Insurance.

1. Property insurance. Insurance cost on property of the nursing facility used to provide nursing facility services. Property insurance should be reported on line 109 of the cost report version MSIR-1 (7-93).

2. Other insurance. Liability, umbrella, vehicle and other general insurance for the nursing facility should be reported on line 140 of the cost report version MSIR-1 (7-93).

3. Workers' compensation insurance should be reported on the applicable payroll lines on the cost report for the employee salary groupings.

(F) Interest and Finance Costs.

1. Interest will be reimbursed for necessary loans for capital asset debt at the Chase Manhattan prime rate on September 1, 1994, plus two percentage (2%) points. For replacement beds, additional beds and new facilities placed in service after August 31, 1995, the prime rate will be updated annually on the first business day of each September based on the Chase Manhattan prime rate plus two percentage (2%) points.

2. Loans (including finance charges, prepaid costs and discounts) must be supported by evidence of a written agreement that funds were borrowed and repayment of the funds are required. The loan costs must be identifiable in the provider's accounting records, must be related to the reporting period in which the costs are claimed, and must be necessary for the operation, maintenance or acquisition of the provider's facility.

3. Necessary means that the loan be incurred to satisfy a financial need of the provider and for a purpose related to recipient care. Loans which result in excess funds or investments are not considered necessary.

4. A provider shall capitalize loan costs (i.e., lender's title and recording fees, appraisal fees, legal fees, escrow fees, and other closing costs), finance charges, prepaid interest and discounts. The loan costs shall be amortized over the life of the loan on a straight line basis.

5. If loans for capital asset debt exceed the facility asset value the interest associated with the portion of the loan or loans which exceeds the facility asset value shall not be allowable.

6. The following is an illustration of how allowable interest is calculated: